Chapter 4
Reducing Health Disparities Experienced by Refugees Resettled in Urban Areas: A Community-Based Transdisciplinary Intervention Model

Jessica R. Goodkind, Ann Githinji, and Brian Isakson

> *"Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death."*
> – WHO Commission on Social Determinants of Health, 2008

There is a growing recognition that social inequities in education, housing, employment, health care, safety, resources, money, and power contribute significantly to increasing health disparities globally, within countries, and even within specific urban environments. Thus, to promote health and well-being for all people, the World Health Organization recommends improving daily living conditions, measuring and understanding problems of health inequity, assessing the impact of action to address these problems, and ensuring equitable distribution of money, power, and resources (CSDH, 2008). Among the diverse populations that bear the burden of social inequities and health disparities are the increasing numbers of refugees and immigrants settling in urban areas. These newcomers often have higher rates of distress, limited material resources, lingering physical ailments, and loss of meaningful social roles and support, all of which are often compounded by racism, xenophobia, other forms of discrimination, and marginalization of their cultural practices.

This chapter presents a case study of the Refugee Well-being Project, a transdisciplinary (TD) research effort that has the specific goal of promoting social justice and reducing health disparities experienced by refugee families in urban areas in the USA. The project involves the development, implementation, and evaluation of an innovative mental health intervention that brings together refugees and undergraduate students to engage in mutual learning and the mobilization of community resources. After describing the project, we discuss the ways in which it represents a TD research approach, our research team and design, and challenges and implications for future research.

J.R. Goodkind (✉)
Division of Prevention and Population Sciences, Department of Pediatrics, University of New Mexico, Albuquerque, NM 87131, USA
e-mail: jgoodkind@salud.unm.edu

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Refugees

There were an estimated 14 million refugees and asylum seekers at the end of 2008 (US Committee for Refugees and Immigrants, 2009, 2008). A majority of refugees remain in their country of first asylum (usually in the "developing" world) or are repatriated to the country from which they fled. Voluntary repatriation to a secure country of origin is preferred because refugees are able to reintegrate into their homeland and a culture they understand, and it simultaneously relieves the temporary host country of economic and cultural stress, thus leading to long-term stability in a region (UNHCR, 1996). Less than 1% of refugees are resettled into a third country in the "developed" world. The United States, Canada, and Australia accept the majority of refugees from this group, and thus North America fulfills an important role in resettling refugees who are unable to return home or remain in their country of asylum. The USA remains by far the largest acceptor of refugees, for example, resettling 79,900 refugees in 2009. (United Nations High Commissioner for Refugees, 2010).

Because refugees are usually survivors of numerous traumas and face many resettlement challenges, they frequently have multiple health needs that require individual attention. However, without a focus on larger social and system changes, in terms of both the living conditions and health care for refugees in their countries of resettlement and the dynamics that create ever-increasing numbers of refugees and internally displaced persons worldwide, the root causes of suffering will remain unaddressed. The result is an apparent tension in regard to the level of intervention on which to focus. For instance, psychologists might typically focus on eliminating refugees' distress through the reduction of individual barriers and problems while sociologists might seek to understand the structure of the health-care system in a particular area and how it impacts refugees' access to health care. Political scientists might work to change global policies and processes that are contributing to the creation of large numbers of displaced persons in the world, while community members might direct their efforts toward organizing and mobilizing for change around a specific local policy that impacts refugees. A TD approach recognizes the importance of all of these efforts and furthermore reveals that they are not mutually exclusive but can be addressed simultaneously within one project.

Refugee Mental Health and Well-being

Mental health cannot be understood outside of a cultural context. What is considered "normal" behavior within one culture may be indicative of mental illness in another. In addition, people from different cultures react differently to distress. For instance, somatization (psychological distress manifested as physical symptoms) is common among many non-Western cultures (Jenkins, 1996; Kirmayer, 1996). Although Western medicine attempts to separate physical and mental health, many cultures consider them inseparable and interrelated and thus take a holistic approach to health (Vontress, 2001). Additionally, Western psychology generally focuses

on the individual and locates causes of distress within the individual (Marsella & Pedersen, 2004; Summerfield, 1999). However, cultures have widely varying beliefs about causes (and therefore cures) of mental illness (Fuertes, 2004). Thus, Western individual psychotherapy cannot be assumed to be culturally appropriate for all people (Miller, 1999). Many refugees have traditional healing ceremonies and support systems from their native cultures (e.g., extended family structure, clan system, community or neighborhood support) that may be more effective (Marsella & Pedersen, 2004).

We also know that attention to the psychological needs of refugees is important but inadequate if other needs are ignored. Rather than an exclusive focus on therapy to deal with the past traumas that refugees have experienced, holistic interventions that address material, social, and educational needs and the challenges of living in a new country, as well as psychological needs, are important. This requires creative approaches and broader definitions of the appropriate roles for psychologists and others who seek to promote the mental health and well-being of refugees. To further elaborate on these issues, it is important to consider the current literature on refugee mental health.

Refugees are at high risk for mental illness because of their exposure to trauma during pre-migration (e.g., sustained warfare, death of family and friends, loss of home), migration (e.g., fleeing home under life-threatening conditions, separation, and death of family and friends), and encampment (e.g., prolonged stays in unsafe and overcrowded camps, uncertainty about future), and because of the extensive stress associated with the post-migration experiences of beginning new lives in exile (Abueg & Chun, 1996). Many studies have found that refugees in the USA experience higher rates of psychological distress than do the general population or other immigrants in the USA (Hirayama, Hirayama, & Cetingok, 1993; Williams & Westermeyer, 1986). Most of these studies have focused particularly on psychiatric symptoms such as post-traumatic stress disorder (PTSD). However, many questions have been raised about the validity of PTSD for refugees from non-Western countries. For instance, although people from various cultures may experience similar symptoms included in PTSD, they may have different values or meanings, including different ideas about what is "normal." In addition, a PTSD diagnosis focuses only on symptoms that may be clinically significant, which may ignore other aspects of individuals' and communities' experiences, including the cultural and political implications of the trauma they have experienced. An emphasis on PTSD can also distract from current and ongoing stressors faced by individuals and may result in certain assumptions about the applicability or appropriateness of individual treatment methods. Finally, the collective traumatization experienced by many refugee groups is not fully captured in the concept of PTSD, which is an individual diagnosis (Nicholl & Thompson, 2004).

Given these concerns, it is important to consider the psychological well-being of refugees more broadly. Some research has examined this by assessing multiple aspects of refugee psychological well-being, including emotional and somatic distress, demoralization, happiness, life satisfaction (Rumbaut, 1989, 1991a, 1991b,), quality of life, and cultural alienation (Birman & Tran, 2008). It is important to

consider definitions of psychological well-being that include both affective and cognitive components and that use measures that have been developed to assess a wider range of experiences rather than only clinical populations and Western-based psychiatric diagnoses.

With some notable exceptions, however, most research on refugee mental health has not only focused on the high levels of distress and clinical diagnoses such as PTSD, depression, and anxiety among refugees but also typically emphasized refugees' past traumas as the cause of these problems. As a result, treatments for refugees have usually emphasized psychotherapy and other individual-focused solutions that address the past traumas. However, recent research has demonstrated that the high levels of distress among refugees are also caused by the daily stressors they face in exile situations, including their marginal position/relative powerlessness in the new place (Miller, 1999; Rumbaut, 1991b), extensive, undesired changes to their way of life (e.g., Rumbaut, 1991b), difficulty achieving their life goals and environmental mastery in a new place (e.g., Dona & Berry, 1999), poverty and daily economic concerns about survival in a new country (e.g., McLoyd, 1990; Paltiel, 1987; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997), loss of community and social support (e.g., Birman & Tran, 2008; Gorst-Unsworth & Goldenberg, 1998; Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997), loss of meaningful social roles (e.g., Lavik, Hauff, Skrondal, & Solberg, 1996), and racism and discrimination (e.g., Silove et al., 1997). These post-migration stressors are particularly burdensome for refugees whose culture, skills, and experiences are vastly different from the predominant culture, language, and work opportunities in the United States.

Therefore, it is important to consider refugee mental health and its promotion from a holistic perspective that recognizes the traumatic circumstances most refugees have had to endure prior to their resettlement while also focusing on the difficulties refugees face in their daily lives in their country of resettlement. In addition, efforts to promote refugee well-being must be culturally relevant to refugees and should build upon their strengths and the resources in their communities. Based on these realities, the goal of the Refugee Well-being Project is to promote the mental health and well-being of refugees by involving undergraduates and refugees in mutual learning and advocacy. Rather than emphasizing only what newcomers to the United States needed to learn to survive here, this project focuses on mutual learning through which refugees and undergraduates both learn and share. Through this process, refugees' experiences and knowledge can be valued and their identities can be validated.

Refugee Well-being Project: Project Description

The primary objectives of the Refugee Well-being Project (RWP) are to reduce health disparities experienced by refugees by (1) improving access to community resources and communities' responsiveness to refugees; (2) promoting and preserving refugees' cultures and valued social roles; (3) increasing English proficiency

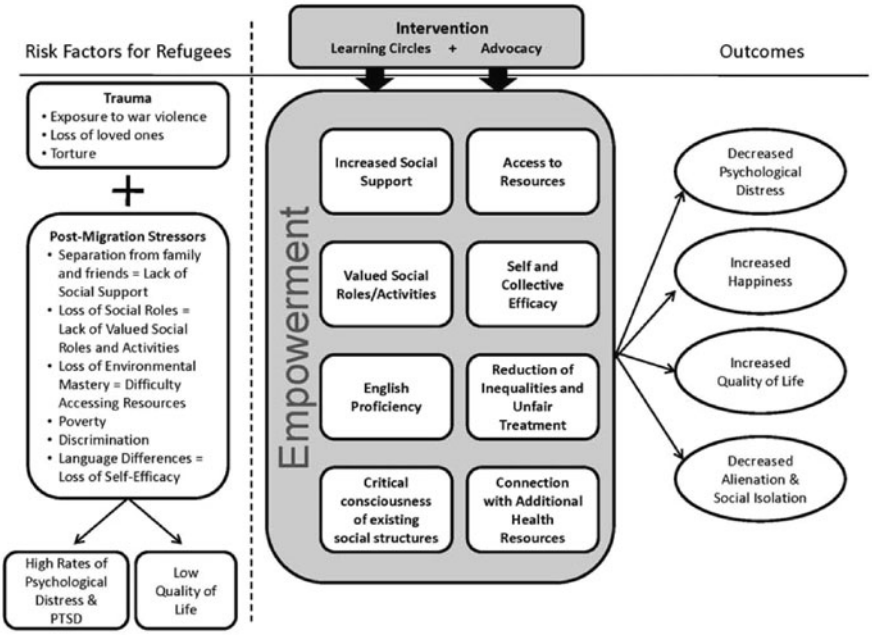

Fig. 4.1 Conceptual model

and literacy; (4) improving intergenerational respect and communication; and (5) enhancing refugees' empowerment and integration in their communities (see Fig. 4.1). The objectives of RWP are achieved through implementation of a 6-month program that has two major components: *learning circles*, which involve cultural exchange and one-on-one learning opportunities for refugee families and undergraduate students, and an *advocacy component* which involves undergraduates advocating for and transferring advocacy skills to refugee families to increase their access to resources in their communities. Refugee participants and undergraduates work together for 6–8 hour per week for 6 months.

Learning circles: Learning circles occur twice weekly. Each meeting is 2 hours and involves refugee adults and children and undergraduate students. Learning circles begin with cultural exchange, which provides a forum for refugees and undergraduates to learn from each other through discussions aided by interpreters. Cultural exchange is facilitated together by one undergraduate and one refugee each evening, and involves discussion of a topic agreed upon and developed by the undergraduate and refugee partners. Cultural exchange discussion topics have included the following: methods for disciplining children, health care, safety issues, labor unions and worker rights, roles of men and women in the USA, Martin Luther King Jr. and the treatment of Black people in America, and performance arts including music, drumming, and dancing. The second component of the learning circles is one-on-one learning, during which time undergraduates and refugee participants work in pairs. Refugee participants choose their areas of learning such as speaking,

reading and writing English, and completing job applications. Child and adolescent activities include homework help, tutoring, and other fun learning activities. A sound relationship between the teacher and the learner is an essential aspect of effective learning. To ensure the development of such relationships, each refugee participant studies with the same undergraduate each time, thus fostering the development of comfort and trust. Undergraduates are also engaged in learning as they learn about the culture, experiences, and knowledge of refugee participants. The learning circle structure provides important flexibility to tailor the meeting to the interests and needs of each group.

Advocacy: The advocacy component of the program is based on the community advocacy model, which has also been successfully applied to women and children who have experienced domestic violence (Sullivan & Bybee, 1999) and to juvenile offenders (Davidson, Redner, Blakely, Mitchell, & Emshoff, 1987). These advocacy projects are predicated on research that demonstrates that access to community resources is fundamental to promoting the well-being of disenfranchised individuals. Once relationships have begun to form between refugees and undergraduates, each student is matched with the one or two refugees with whom they work in the learning circles to serve as an advocate for them. The undergraduates spend an additional 2–4 hours each week (outside of the learning circles) with their refugee partners to provide advocacy to mobilize community resources based on unmet needs identified by the partner. The emphasis of advocacy is on transferring the advocacy skills to the refugee families so that their increased access to resources and self-sufficiency is sustained after their involvement in the program ends. Example areas of advocacy include *health* (e.g., accessing and utilizing health care and providing cultural "interpretation"); *housing* (e.g., finding affordable housing, locating household items); *school* (e.g., working with educators and refugee families to monitor student progress and improve students' attendance); and *other resources* (e.g., helping families access cheap or free clothing, food, and diapers; assisting in immigration and residency issues; helping connect families with free tax services).

It is important to note that the learning and the advocacy are two inextricable parts of one holistic program. The RWP is centered around the learning circles, which provide participants with opportunities to discuss their advocacy efforts, share ideas and resources, and get assistance from the interpreters. Besides emphasizing what refugees need to learn to survive in the USA, the program also focuses on mutual learning, whereby refugees both learn from and teach Americans. Through this process, refugees' culture, experiences, and knowledge are valued and utilized in the promotion of their well-being. By design, the program has the potential to incorporate the strengths and needs of refugees while addressing multiple aspects of the empowerment process (Parsons, Gutierrez, & Cox, 1998): (1) building skills and knowledge for critical thinking and action (e.g., English proficiency, advocacy skills); (2) changing attitudes and beliefs (e.g., value of own culture and knowledge, increased self-efficacy); (3) validating through collective experiences; and (4) securing real increases in resources and power through action and system-based advocacy. In addition to addressing the social determinants of health, the

learning circles and advocacy also focus directly on connecting refugees to health resources (including physical health, mental health, dental, and optical care) and on improving refugees' health through cultural exchange discussion topics on dental hygiene, sexual health, prenatal care, and how to use health-care systems in the USA.

Development of the Project

The idea for the Refugee Well-being Project was initially conceived by the first author and Hmong[1] community members in Lansing, Michigan. We worked together to conduct several studies. First, we focused on Hmong refugees living in three public housing developments. We wanted to understand why Hmong families were not accessing resources from community centers that were 100 feet from their homes and did not feel they were able to participate in, or had anything to contribute to, their communities. Their marginalization and inability to make use of the resources in their social environments were evident. This lack of understanding and ability to navigate the system, the accompanying feelings of powerlessness, and a lack of access to resources seemed to be some of the most fundamental and important exile-related stressors facing these Hmong refugees. Quantitative and qualitative interviews revealed that only practical barriers (e.g., language, lack of child care) and discrimination were related to non-participation and that, in turn, participation was positively related to psychological well-being. We concluded that social contexts needed to be created which address issues of discrimination and exclusion and which enable refugees to develop the abilities and skills necessary for them to meaningfully participate in their communities and access resources (Goodkind & Foster-Fishman, 2002).

The findings from this study formed the basis for our next study, which was the first author's dissertation. We had the dual goals of developing and evaluating the intervention (described previously) designed to enhance refugees' psychological well-being by creating change at multiple levels and of furthering our understanding of these change processes. The study involved 28 Hmong adults and 27 undergraduate students. Using a mixed-method, longitudinal design, we found significant increases in English proficiency, access to resources, quality of life, and knowledge of US history and government (needed to become a US citizen), as well as significant decreases in psychological distress among refugee participants (Goodkind, 2005). Other outcomes that were supported by our qualitative data included increased valuing of participants' knowledge and experience, validation of participants' ethnic identities, appreciation of the strength and resiliency of refugees, recognition of society's responsibility in the process of refugee resettlement and the need for system-level change, and increases in participants' environmental mastery and self-confidence (Goodkind, 2006).

[1] Hmong people are an ethnic group in China and Southeast Asia.

Although the study was originally time-limited (both because it was the first author's dissertation and more importantly because it was essential to examine the effects of the intervention before establishing it as an ongoing project), several impacts and changes were sustained following the 6-month intervention (for more details, see Goodkind, Hang, & Yang, 2004). Unfortunately, there was not enough time to help create a sustainable model in Lansing that was run by the Hmong community in partnership with others. However, we felt it was important to continue this work in other urban areas with large immigrant and refugee populations. Therefore, when the first author assumed a faculty position at the University of New Mexico, she began talking with refugee community members and service providers in Albuquerque about the issues they were facing, and she shared with them the model she had developed with Hmong refugees.

After initial qualitative background research with refugees and providers, we initiated the second phase of the Refugee Well-being Project in August 2006 with African refugee families. Between 2002 and 2007, 1,226 refugees were resettled in New Mexico. Of this number, 160 (13%) were Africans from the countries of Burundi, Cameroon, Congo, Eritrea, Ethiopia, Liberia, Somalia, Sudan, and Togo. In New Mexico, African refugees represent a high need, underserved population. Most families are single mothers with multiple children. Many have witnessed or experienced torture. Additionally, most health-care providers are unaware of their cultural backgrounds and experiences. In addition to working collaboratively with the African refugee community to address their mental health and well-being, we also thought it was important to test the applicability of the model to other communities, contexts, and cultures. Working together, we adapted the model in several ways. First, all research team members wanted to broaden the model to include children and adolescents. This was based on a mutual recognition of the unmet needs of refugee children, the intergenerational conflicts many families were experiencing, and the impact of both of these on families' health and well-being. We also saw the potential for the learning circles to be a setting where refugee children could learn about their traditional cultures from their parents and parents could learn from their children about their experiences in school and the issues that were important to them.

The Refugee Well-being Project has completed its third year in operation in Albuquerque and has involved a total of 83 African refugees (46 African refugee children and 37 adults) and 54 UNM undergraduate students. We have had a waiting list of refugee families each year because so many want to participate and attendance at the learning circles is extremely consistent. Our process, fidelity, and qualitative data suggest that the program has positive effects on participants' mental health, access to resources, quality of life, social support, and English proficiency. In addition, refugees reported that they felt welcomed and accepted in the USA, refugee children made important academic progress and became integrated in recreational activities, and refugee adults had improved employment opportunities. We are in the process of analyzing our quantitative data from the first 2 years of the project.

The TD Approach of the Refugee Well-being Project

The Refugee Well-being Project evolved through long-term relationships and collaboration among university and community partners. We began with a fundamental belief that all people have knowledge and expertise that they can use to solve their problems. We based our efforts on several other guiding principles, including the importance of (1) locating problems beyond the level of the individual, (2) viewing diversity as a strength, not deviance, and (3) developing an empirical base for social action. To adhere to these principles and to achieve sustainable change that supports the well-being of refugees and other newcomers, we employed several strategies: (a) creating alternative settings and social roles; (b) recognizing people as experts on their well-being and healing; (c) building on individual, family, and community strengths; (d) facilitating critical awareness and collective action; (e) developing and connecting people with local resources and infrastructure; and (f) advocating for more just policies and laws. We also recognized that addressing the issues faced by newcomers in urban areas requires emphasis on multiple domains or life areas, including psychological, physical, educational, cultural, social, and material. Thus, a unidisciplinary perspective would be inadequate. Transdisciplinarity, as defined and applied in our study, has involved the following:

- A focus on social determinants of health and social justice
- Collaboration among researchers and non-academic groups
- Inclusion of both scientific and non-scientific knowledge (e.g., one of fundamental tenants of the program is mutual learning and the importance of the knowledge, experience, and expertise that newcomers possess)
- Integration of knowledge from multiple academic disciplines, including community psychology, clinical psychology, anthropology, social work, and education
- Explicit research goals that include knowledge generation, social change, and empowerment of all participants
- Open discussion of process as well as outcomes
- An ecological model that integrates multiple levels of analysis
- Integration of health and social sciences methods and methodologies
- Involvement of students to foster intergenerational transfer of knowledge
- Advocacy training to transfer skills to students and refugee families in order to contribute to sustainable change

The Refugee Well-being Project works towards social justice in several ways. One primary mechanism is through its approach to education and learning. Newcomers to the United States often need to acquire new skills and knowledge such as English proficiency; knowledge about political, social, and economic processes; literacy; and job skills. This type of learning is termed instrumental learning and is an important aspect of empowering individuals because it enables them to acquire the skills and knowledge they need to participate in their communities

(Zimmerman, 1995). Learning English is also important because English proficiency is an essential resource for the economic and social adaptation of immigrants and refugees (Rumbaut, 1989) and is negatively related to depression, anxiety, and other mental health problems among refugees (Rumbaut, 1989; Westermeyer, Neider, & Callies, 1989). Moreover, learning can further empower disenfranchised individuals and communities by raising their consciousness, increasing their understanding of the structural forces affecting them, and providing mechanisms through which they can work collectively for social justice. This type of learning is also referred to as popular education (Cunningham, 1992) or transformative learning (Cunningham, 1998) and places individuals and their experiences in the center of their own learning, as subjects (rather than objects) of their learning (Freire, 1998). The popular education perspective argues that individuals are shaped by their context, including their social location, and therefore it focuses on transforming social structures in order to achieve a more just society.

The work of social worker Jane Addams and her colleagues is also fundamental to an understanding of adult/popular education for refugees and immigrants and the educational component of the intervention. Jane Addams formed one of the first settlement houses in Chicago because she felt that all community members must share responsibility for immigrants' well-being. Her actions were predicated on several beliefs, including the interdependence of all human beings and the importance of education as the basis of social change and the vehicle through which immigrants could contribute their unique abilities, skills, and vision to their communities. She believed that education must begin from the experiences of the learners but must also help learners to see their place in the larger world (Addams, 1964). It is important to note that popular education and Freire's and Addams' approaches to learning are intimately linked to the processes of community participation, empowerment, and access to resources. They recognize education as a social as well as an individual act (Cunningham, 1998) and they problematize a sole focus on individual learning without accompanying change in social structures or mobilization of resources.

Furthermore, the RWP provides a unique service learning opportunity for undergraduate students through which they are able to apply their academic skills and knowledge to benefit their community and work towards social change. Undergraduates enroll in a two-semester upper-division psychology/anthropology course. They receive intensive training and preparation during the first 3 months. For the final 5 months of the program, training is replaced by weekly supervision. This educational experience raises awareness among undergraduates of the need for social change and methods for working towards creating a more just society.

The Refugee Well-being Project was designed to enable participants to take greater control over their lives by providing mechanisms through which they could define and solve their own problems rather than rely on outside "experts." Gaventa (1995) points out both external barriers (e.g., lack of organization, lack of voice in community, limited funds to influence politics) and internal barriers (e.g., lack of critical consciousness, lack of understanding of possibilities for social change), which exclude many disenfranchised people from meaningful participation in their communities. Thus, effective participation and real gains in power require both

community organizing in order to bring a group together and to establish a power base and popular education in order to enable individuals to transform how they think about themselves and their place in the world (Gordon, 1998). This project addresses both of these components by offering opportunities for transformative learning in the learning circles and for community organization through both cultural exchange and the mobilization of community resources.

Research Design and Research Team

Our commitment to social action is matched by an equal dedication to rigorous research that measures the intended impacts and any potential unintended consequences of our efforts. Our current research team includes a community psychologist, a clinical psychologist, an anthropologist, four former and current undergraduate students who were previously involved as student advocates in the project, and three Africans who were previously involved as refugee participants in the project. Our study employs a within-group longitudinal design with four data collection points over a period of 9 months. Participants in the intervention are assessed using a quantitative interview protocol: pre-intervention, midway through the intervention, post-intervention, and at a 3-month follow-up. In addition, participants participate in two open-ended qualitative interviews: one when they are initially recruited into the study and one when the intervention ends. These qualitative interviews allow for in-depth understanding of participants' experiences and help support and explain quantitative data. A longitudinal design allows us to examine the processes at work in the intervention and to explore potential modifiers, such as characteristics of participants who are impacted differently by the intervention.

Although a true experimental design might appear to be an ideal method to test the efficacy of the intervention, our research team recognizes that this type of design is not feasible for several reasons. First, as opposed to a large, unacquainted population, the African refugee community in Albuquerque is relatively small and members are well aware of events affecting each other. Therefore, it would be culturally inappropriate to offer some refugees the opportunity to participate while excluding others. Also, it is likely that participants who were assigned to an experimental group but had relatives in a control group might decline to participate or, if they did participate, might share the intervention with their relatives. Quasi-experimental designs are often the best designs for certain studies, given resource, practical, and logistical constraints. Rather than a simple pre-/post-design, this study employs a longitudinal design with multiple time points which allows for more thorough examination and elimination of some potential threats to validity such as maturation, history, testing, attrition, and implementation fidelity. In addition, we include concrete measures of knowledge and skills, which are important because they are unlikely to be affected by participants' potential desires to give increasingly positive responses due to the attention they received.

A TD approach has been essential but not without challenges. Because the project was originally conceived within a community psychology framework, which is a field that explicitly values and incorporates different disciplinary perspectives, there was an initial expectation for and underlying openness to an approach that integrated strengths from multiple disciplines. Furthermore, because our research team members are all in the beginning stages of their careers and/or part of a research project for the first time, we may have been less bound to particular disciplinary perspectives. However, we certainly had to devote significant time to examining our disciplinary assumptions and sharing our perspectives with each other. For instance, the non-scientist members of our research team have emphasized the lack of feasibility and acceptability of a randomized experimental design and the importance of including qualitative methodologies so that we can represent participants' experiences in their own words. These important contributions required other members of the research team to be open to combining methods and methodologies and thinking creatively about research designs. Perhaps our largest challenge has been obtaining acceptance and funding within our university's School of Medicine, many members of whom have tended to view our study as non-scientific, less rigorous, unlikely to be funded by extramural funding sources, and/or outside of the realm of traditional biomedical research that typically occurs in schools of medicine.

Discussion

The Refugee Well-being Project is in its fourth year. A total of 111 refugees and 81 undergraduate students have participated in the program. Our research team continues to grow as former participants (both refugees and undergraduates) become facilitators, research coordinators, interviewers, and co-investigators. Furthermore, we have been successful in developing a preliminary body of evidence demonstrating the positive effects of the project. In addition, we have initiated efforts to disseminate our model to research teams in Arizona, California, Illinois, Oregon, and Ontario, Canada.

Taken together, these accomplishments are encouraging. However, we believe it is also important to note our limitations and challenges. Our primary concern involves the short intervention period and the degree to which we have been able to achieve long-term, sustainable change. Our observations and qualitative and quantitative interview data suggest that the types of processes that are occurring, the skills and knowledge we are trying to help participants build, and the social change efforts we are engaged in collaboratively require longer periods of time. Empowerment is a process that takes time and that must include real and enduring increases in power and resources (Speer & Hughey, 1995). We have seen some evidence that this has occurred in our communities. However, we believe that the full potential of our research has not yet been achieved because we have not resolved issues of sustainability. We envision an ongoing project involving learning circles and advocacy in which community members participate as long as they would like. We are considering how this type of endeavor can be sustained and institutionalized within

refugees' communities. An ongoing partnership between universities and refugee communities and organizations in which undergraduates make a two-semester commitment and refugee community members participate as long as they want is our ideal. As such a project grows and social and material resources within our communities develop, coordination and ownership can be increasingly shifted to the refugee communities. However, many refugee communities have so few resources that it takes time to reach this ultimate goal. Our research demonstrates that universities possess untapped resources that have great potential for improving the well-being of refugees and that undergraduates can be effective change agents and engage in relationships with refugees that are mutually beneficial. Therefore, we think this research and intervention model has great potential for contributing to reduction of health disparities in urban communities and to sustainable change.

Together, our research team has worked to address urban health problems by creating change at multiple levels. We have attempted to measure change at these different levels by assessing individual psychological well-being and quality of life as well as changes in our community's responsiveness to the needs of newcomers. However, some of the important changes that are fundamental to improving our urban settings are best expressed by participants.For example, the words of a 37-year-old man from Burundi:

> When I was leaving Africa some of our friends were like, "Well, you're going to a foreign country, you're going to live in your house, nobody is going to come say hello, there are no black people there from Africa, you'll live all by yourself." . . . As refugees, we receive so much food, and clothing, and shoes, but then would these white people, are they going to accept food and water from us? And so you guys [undergraduate students] came in and you were eating with us and hanging out with us, and we were completely in shock, and we were so amazed that a whole group of white people would come to our house, and our friends find it difficult to believe that such a thing happened. A lot of people are really shocked that this has happened. So our friends in Tanzania are asking, "So the American people, do they really come up and say hello to you, do they greet you and hang out with you?" And we say, "Oh yeah, they do! And they're our friends, and we hang out," and they're like, "Well then America is a good country".

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